1POINT SOLUTIONS

FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT FORM

Name (Please Print)	Employer	Social Security Number
Street Address	City, State, Zip	Phone Number

Flexible Spending Card Expenses

Item	Date	Provider	Amount
M1.			
M2.			
M3.			
M4.			
M5.			
M6.			
M7.			
M8.			
		Total Charged on Flexible Spending Card:	

Out of Pocket Expenses

Item	Date	Provider	Amount
R1.			
R2.			
R3.			
R4.			
R5.			
R6.			
R7.			
R8.			
R9.			
		Total Out-of-Pocket Expenses To Be Reimbursed:	

Will this reimbursement be made via direct deposit? ☐ Yes ☐ No

(This claim will not be processed without your signature.) I certify that these eligible expenses have been incurred by me or my eligible dependent and are not for cosmetic purposes but for the treatment of an illness, injury, trauma, or medical condition. I understand that expense incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed, and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature _____ **Date** / /

MAIL TO:	Instructions:	FAX TO:
1Point Solutions FSA Claims Dept. PO Box 1558 Dickson, TN 37056	Please complete the above form. Photocopy your receipts and write the number on each receipt corresponding to the item number on expenses list. Fax or mail form. All claims received before 2:00pm Central Time will be processed the same day. Please keep copies of all receipts. Please call (866) 602-1900 x2 or e-mail cs@1pointsolutions.com if you have any questions or concerns.	1Point Solutions FSA Claims Dept. (866) 254-1927 No Cover Page Req.

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